



**RI MEDICAL ASSISTANCE PROGRAM
PRIOR AUTHORIZATION REQUEST FORM**

PA10-2005:
**REQUESTS FOR AGENTS
TREATING PULMONARY HYPERTENSION**
FAX TO:
DEPARTMENT OF HUMAN SERVICES
ATTN: PHARMACIST
401-462-6336

CLIENT NAME _____ DOB: _____ MEDICAID ID NUMBER: _____
PRESCRIBER NAME: _____ PRESCRIBER DEA #: _____
PRESCRIBER OFFICE ADDRESS: _____
OFFICE PHONE NUMBER () _____ - _____
REQUESTER NAME: _____ RN /MD /R.Ph / _____
PHONE NUMBER () _____ - _____ FAX NUMBER () _____ - _____
DRUG REQUESTED : _____ QTY / FILL _____

CRITERIA SPECIFICATIONS ARE AVAILABLE BY CALLING **(401) 784-8100** OR AT WEB ADDRESS
www.dhs.ri.gov/dhs/heacre/provsvcs/mpharpa.htm

IS PRESCRIBER IS A CARDIOLOGIST OR PULMONOLOGIST? YES / NO
DOES THE PATIENT HAVE PRIMARY PULMONARY HYPERTENSION? YES / NO
IF YES, PLEASE LIST THE APPROPRIATE ICD-9 CODE. ICD9 CODE _____
DOES THE PATIENT HAVE SECONDARY PULMONARY HYPERTENSION? YES / NO
IF YES, PLEASE LIST THE APPROPRIATE ICD-9 CODE. ICD9 CODE _____
IF THE PATIENT DOES HAVE SECONDARY PULMONARY HYPERTENSION, DO THEY ALSO HAVE A DIAGNOSIS OF CONNECTIVE TISSUE DISORDER? YES / NO
IF YES, PLEASE LIST THE APPROPRIATE ICD-9 CODE. ICD9 CODE _____
WHAT IS THE FUNCTIONAL WHO CLASS? I. _____
II. _____
III. _____
IV. _____

COMMENTS:

PREScriBER SIGNATURE _____ **DATE** _____

By Signature, the Prescriber confirms the criteria information above is accurate, verifiable by client records and available for review upon request.

PA # _____ APPROVED _____
DENIED _____
PENDING ADDITIONAL INFORMATION _____
DATE /TIME OF RECEIPT _____
DATE/TIME RESPONSE _____
REVIEWER _____
COMMENTS:

DHS RI PRIOR AUTHORIZATION
FAX Number 401-462-6336

Contact EDS Customer Service for Questions:
401-784-8100